STATE OF ARIZONA
Government Information Technology Agency (GITA)

Rural Health Information Technology Adoption (RHITA) Grant Program
FY 2006-07

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I. Funding Opportunity Description

A. Purpose

The primary purpose of the Rural Health Information Technology Adoption (RHITA) Grant Program is to facilitate the adoption of health information technology (HIT) by Arizona rural health care providers.

The Governor and Legislature of Arizona have appropriated to the Government Information Technology Agency $1.5 million to "provide information technology grants to rural health care providers" (47th Legislature; Second Regular Session; Chapter 350, Section 27). The purpose of these grants is to enhance the health information technology (HIT) adoption level of recipients leading to greater quality and efficiency in their health care delivery, enabling health information exchange (HIE) with other providers, and lowering Arizona's health care costs. This purpose is in accordance with both the Governor Napolitano's Executive Order 2005-25 (August 30, 2005) regarding the Arizona Health -e Connection Call to Action Summit, Steering Committee, and Roadmap creation and President Bush's Executive Order 13335 (April 28, 2004) calling for widespread adoption of electronic health records within ten years.

1. Desirable outcomes of this grant program are to:
    a. Improve the quality and reduce the cost of health care, thus furthering the public good, through:
        i. Reduction of medical errors to increase patient safety
        ii. Avoidance of duplicative medical procedures
        iii. Ensuring patient health information is available at the point of care
        iv. Providing consumers with their own health information to encourage greater participation in their own health care decisions
        v. Allowing rural clinicians to participate in local, regional, (e.g., Regional Health Information Organization), and statewide data exchange initiatives
        vi. Using information technology applications to increase the efficiency of the scarce medical workforce in Arizona Medically Underserved Areas (AzMUAs)
        vii. Improving Arizona's ability to attract and retain health care professionals (e.g., doctors, nurses).
    b. Reduce State expenditures by controlling health care costs:
        i. Research overwhelming states that the healthcare payers will obtain the greatest benefit and cost savings associated with adoption of health information technology by providers[1]. As

[1] The RAND Corporation, "*Extrapolating Evidence Health Information Technology Savings and Costs," 2005.* Dr. Jay Himmelstein, University of Massachusetts Medical School, *"Establishing a Foundation for Medicaid's Role in the Adoption of HIT,"* 2005. Markle Foundation, *"Promoting Electronic Health Records: Incentives and Connectivity."*

the State of Arizona is the largest employer in the State, and also self-insured, the State should reap substantial benefits from provider adoption of HIT.

ii. Rapid adoption of e-health connectivity will reduce medical costs associated with duplication and patient safety issues (AHCCCS presentation; May 19, 2006).

iii. Facilitate time-saving and more accurate reporting to government agencies such as the Arizona Department of Health Services.

c. Enhance the business environment for small and large employers.
   i. Health care costs for businesses continue to rise at five times the rate of inflation. If Arizona is able to initiate control on health care costs through implementation of HIT, it should create a more beneficial environment in which businesses can locate, and grow.

d. Fulfill the role of the Government Information Technology Agency in relation to State agencies (A.R.S. § 41-3504), and per Governor Napolitano's Executive Order 2005-25 to:
   i. Solicit input and participation in the creation of an e-health information infrastructure for Arizona.
   ii. Serve as statewide coordinator for information technology resources
   iii. Continuously study emergent technology and evaluate its impact on this state's system
   iv. Spend and account for grants for the conduct of programs that it deems consistent with the overall purposes and objectives of the agency

e. Enhance health information availability, exchange, and reporting capabilities in support of homeland security, and epidemic/pandemic readiness and response.

2. Health Information Technology (HIT) that may be planned or implemented through this program includes, but is not limited to, the following:

   a. Electronic Health Records (EHR) / Electronic Medical Records (EMR)
   b. E-Prescribing
   c. Personal Health Records (PHR)
   d. Personal Health Summary (PHS)
   e. Case Management Information Technology
   f. Disease Management Information Technology
   g. Practice Management Information Technology
   h. Results Delivery (e.g. lab results)

B. Program Background

1. Understanding the National Agenda (taken from the Health-e Connections Briefing Paper; which can be downloaded in its entirety from: http://www.azgita.gov/tech_news/2005/ehealth/Briefing.pdf

a. Background

Leading authorities such as the Institute of Medicine (IOM), some of the nation's largest employers, provider and physician groups across the country, Members of Congress and nearly every federal government healthcare agency have called for investment in electronic health information systems deployment. President Bush, during an address in April 2004, declared that every American would have an electronic health record within ten years.[2]

Towards this end, the President created a new sub-Cabinet Level post: the National Coordinator for Health Information Technology, reporting to the Secretary of the Department of Health and Human Services. Secretary Mike Leavitt said that adoption of HIT and health information exchange will provide "better care at lower cost, fewer medical mistakes, and less hassle."[3] Secretary Leavitt is working with hospitals, physician practices, insurance companies and vendors through a federally-charted, private-public collaboration called the American Health Information Community. The American Health Information Community will provide recommendations to HHS on how to make health records interoperable, and assure that the privacy and security of those records are protected.

There is enormous momentum around Health Information Technology (HIT) and Health Information Exchange (HIE) at the national and local levels. The financial imperative for reducing our health care costs is clear: U.S. healthcare spending rose 7.7 percent to $1.68 trillion in 2003, and the Centers for Medicare and Medicaid Services' states that domestic healthcare spending in 2004 totals about $1.8 trillion, and will continue to grow faster than the economy.[4-5] In 2011, the first group of baby boomers will reach the age of 65, marking the beginning of 77 million baby boomers approaching a time when they will use healthcare resources and consume a large portion of our healthcare services.[6]

The crisis is already impacting the nature and composition of the healthcare provider workforce. Escalating malpractice insurance

[2] M. Allen, "Bush Touts Plan for Electronic Medicine," Washington Post, May 28, 2004
[3] Secretary Leavitt, "Leavitt Discusses Importance of Health IT," Collins, Deseret Morning News, August 17, 2005
[4] Trends: Health Spending Growth Slows in 2003. Smith et al. Health Affairs. 2005;24:185-194.
[5] The Washington Times, "Public spending on healthcare on the rise," The Washington Times, Ellen Beck, UPI; February 23, 2005.
[6] "65+ in the US," US Bureau of the Census, 1996

premiums and the increasing challenges of an overly complex healthcare system are causing many clinicians to leave medical practice altogether. The United States is in the midst of a nursing shortage that is expected to intensify; according to the U.S. Bureau of Labor Statistics, more than one million new and replacement nurses will be needed by 2012.[7] In a July 2002 report by the Health Resources and Services Administration (HRSA), thirty states were estimated to have shortages of registered nurses in the year 2000. The shortage is projected to intensify over the next two decades with 44 states plus the District of Columbia expected to have RN shortages by the year 2020.[8]

Access problems, already made difficult by the complexity of the healthcare system, are further complicated for those lacking appropriate healthcare coverage. Today, 15.8 percent of the U.S. population is uninsured,[9] leaving close to 44 million Americans without financial coverage for major medical emergencies and/or access to needed medical care on an ongoing basis.

Concern about medical errors is prevalent. Studies sponsored by the Agency for Healthcare Research Quality (AHRQ) and reports by institutions such as the Institute of Medicine (IOM) and other highly regarded organizations show patient safety is among the top healthcare system challenges. Adverse events occur in up to 3.7 percent of hospitalizations, with up to 13.6 percent of those hospitalizations leading to death.[10] Similar statistics are found in the outpatient environment, where one study revealed that adverse drug events occur in 5 to 18 percent of ambulatory patients.[11] Forty-seven percent of patients surveyed in 2000 by AHRQ and the Kaiser Family Foundation said they were concerned about experiencing a medical error. Further, a 2001 Robert Wood Johnson survey found that 95 percent of doctors, 89 percent of nurses and 82 percent of healthcare executives reported serious medical errors.

While there are many opportunities to improve care through the use of clinical guidelines and decision support, currently very few healthcare providers utilize the available resources. According to a 2003 New England Journal of Medicine report documenting the appropriate treatment for 7,528 adults revealed that American adults, on average, receive only a little more than half (54.9 percent) of the healthcare measures recommended for their conditions.[12] Bringing clinical

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[7] *Table 2, Employment by occupation, 2002 and projected 2012,* in "Occupational employment projections to 2012," published in the *February 2004 Monthly Labor Review*.
[8] HRSA, *Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020*, http://bhpr.hrsa.gov/healthworkforce/reports/rnproject/default.htm
[9] Managed Care Outlook, "Number of uninsured unchanged; policy proposals aim to reduce," May 2001.
[10] Ibid
[11] Leape LL, Bates DW, Cullen DJ, Cooper J, Demonaco HJ, Gallivan T, et al. Systems analysis of adverse drug events. ADE Prevention Study Group. *JAMA*. 1995;274: 35-43.
[12] Ibid

knowledge and information about the patient to the point of care through HIT will help to close the gap between what the evidence tells us in accordance with guidelines and treatment protocols, and the care, interventions, and procedures that are actually delivered.

As if these challenges are not enough, the U.S. healthcare delivery system is now confronted by the prospect of a public health crisis once unthinkable. Recent threats including those related to severe acute respiratory syndrome (SARS) and West Nile Virus, as well as the ongoing threat of bioterrorism, underscore the vital significance of disease surveillance and interoperability in protecting the public from natural and unnatural outbreaks. The momentum to adopt HIT and HIE has only been heightened by our recent natural disasters, such Hurricanes Katrina and Rita, which highlight the importance for HIT adoption and interoperability to provide care to our citizens, regardless of where their health records were created.

Harnessing HIT for Better Patient Care

Today, the United States is at an important crossroads regarding the management and delivery of healthcare. Evidence is clear and compelling; the way care has been delivered in the past does not fit the health care environment today. We must become more efficient, more effective, and more creative in our thinking. It is here that HIT holds enormous potential for improvement.

The U.S. healthcare system, representing approximately $1.68 trillion or 15.3 percent of the nation's gross domestic product,[13] is highly fragmented. Information abounds, but is stored in a variety of formats (often paper-based), leaving vital pieces of a patient's history, for example, unconnected. It is widely recognized that there are industry-wide productivity losses resulting from the inefficiencies of the system. Each healthcare entity, public and private—including clinicians, hospitals, insurers, and researchers—gathers and holds its own information, most often in paper form. In an electronic information age when vital data can be transferred electronically at the speed of light, only a fraction of healthcare data is accessed and transferred digitally. More than 90 percent of the estimated 30 billion healthcare transactions in the United States each year are still conducted by phone, fax or mail.[14] Studies have shown that nearly 30 percent of healthcare spending in the United States, or up to $300 billion each year is for treatments that may not improve health status,

[13] Centers for Medicare and Medicaid Services, Office of the Actuary. "National health expenditures and selected economic indicators – calendar years 1980 – 2012."
[14] Michael Menduno, "apothecary.now," Hospitals and Health Networks, July 1999, 35-36

may be redundant, or may be inappropriate for the patient's condition.[15]

The absence of readily available, comprehensive, patient-centric health information and access to clinical knowledge negatively affects healthcare at every level. Research shows that physicians spend an estimated 20 percent to 30 percent of their time searching and organizing information.[16] Alarmingly, 10 to 81 percent of the time, physicians do not find patient information they need in a paper-based medical record.[17] As a result, it is estimated that 20 percent of lab and x-ray tests are performed because prior results are unavailable and that 1 in 7 hospitalizations occur because prior patient information is not available.[18]

An expanding body of research points to HIT's potential for reducing the inefficient use of resources.[19] For example, one study indicates that the use of ambulatory EHRs can produce a savings of $78 billion to $112 billion annually.[20] Such cost reductions are realized because duplicative procedures are avoided, staff productivity is increased, medical information is conveyed more efficiently, and medical claims are processed more efficiently.

Utilization of Computerized Physician Order Entry (CPOE) is another case in point. According to study by the Center for Information Technology Leadership (CITL), full adoption of CPOE in the ambulatory environment can generate an annual savings of $44 billion in reduced medication, radiology, laboratory, and hospitalization expenditures.[21] Another CITL study indicates that standardized healthcare information exchange among healthcare IT systems could deliver national savings of $86.8 billion annually after full implementation and could result in significant direct financial benefits for providers and other stakeholders.[22]

The CITL CPOE data also showed that more than two million adverse drug events and 190,000 hospitalizations per year could be prevented using IT.[23] Similarly, evidence from a Brigham & Women's Hospital study concluded that use of CPOE, could reduce error rates by 55 percent,

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[15] See Framework for Strategic Action supra note # citing Wennberg, J.E., E.S. Fisher, J.S. Skinner, Health Affairs Web Exclusive, W96-W114 (2002); Wennberg, J.E., et al. Brit. Med. J. 328, 1-5 (2004); Fisher, E.S., et al. Ann. Intern. Med. 138, 273-87 (2003) and Fisher, E.S., et al. Ann. Intern. Med. 138, 288-98 (2003).
[16] Federal Telemedicine Update, March 15, 2004
[17] Clinical Information: Achieving the Vision, 2002; Kaiser Permanente
[18] William A. Yasnoff, M.D., National Health Information Infrastructure: Key to the Future of Health Care, UD Dept. of Health and Human Services, 2002.
[19] See Framework for Strategic Action supra note # citing the following sources. Reduce laboratory and radiology test ordering by 9% to 14%. Bates D.W., et al. Am. J. Med.106(2), 144-50 (1999); Tierney, W.M., et al. Ann. Intern. Med. 107(4), 569-74 (1987); Tierney, W.M., et al. N. Engl. J. Med. 322(21), 1499-1504, (1990); Tierney, W.M., et al. JAMA 259(8), 1194-98 (1988). Others noted in Framework.
[20] The Value of Computerized Provider Order Entry in Ambulatory Settings. Wellesley, MA: Center for IT Leadership and Pan, E., D. Johnston, J. Adler-Milstein, J. Walker, B. Middleton, "The value of healthcare information exchange and interoperability," Wellesley, MA: Center for IT Leadership, 2003.
[21] The Value of Computerized Provider Order Entry in Ambulatory Settings, Center for Information Technology Leadership, 2003
[22] "The Value of Healthcare Information Exchange and Interoperability," CITL, Partners HealthCare System, Boston, MA. 2004 – Published and distributed by the Healthcare Information and Management Systems Society
[23] Ibid

from 10.7 to 4.9 per 1,000 patient days.[24] Yet another study, this one conducted by Kaiser Permanente found that when physicians used a CPOE system in treating intensive care patients, incidents of allergic drug reactions and excessive drug dosages dropped by 75 percent. The study also showed that the average time spent in the intensive care unit dropped from 4.9 days to 2.7 days, reducing costs by 25 percent.[25]

There has been a large amount of research focused on the benefits of HIT; however, cost models for HIT use and implementation for both regional and national health information networks have been lacking. Recently, a national health information network (NHIN) report (authored by an expert panel of nationally renowned health care experts) gives important insight into broad functionality and interoperability costs. This study, published in the *Annals of Internal Medicine*, reported that to achieve an NHIN it would cost $156 billion in capital investment over 5 years and $48 billion in annual operating costs.[26] It is particularly important because it is the first study of its kind to break down NHIN costs into the subcategories of capital costs, functionalities and interoperability and offers tangible numbers on the capital, operating and interoperability costs that accrue to each healthcare stakeholder. Report findings will inform the evolving federal debate on financing and incentives and cost/benefit models. It also suggests that the debate over HIT legislation and funding must reach a new level of sophistication to be relevant.

Healthcare IT Investment: Playing Catch-up

Despite evidence that IT improves the quality, safety and efficiency of patient care, the healthcare industry lags far behind other industries in IT investments. For example, while IT investment claimed 6.5-11.1 percent of revenues in the consumer services, insurance and financial industries in 2002, only 2.2 percent of healthcare industry revenues were spent on information technology in the same year. HIT expenditures are expected to grow over the next several years. Growth estimates vary from 5-7 percent, up to 18 percent per year.[27]

The low adoption rates are also seen in planned healthcare spending. For example, 40 percent of healthcare organizations surveyed planned to spend 1.5 percent or less of their total operating budgets on IT, and 36 percent set spending at 2 to 4 percent.[28] In comparison, the average IT investment for other industries is 8.5 percent.[29] On the individual practitioner level, only 5 to 10 percent of physicians use electronic

[24] Bates et al., JAMA, October 1998
[25] *Clinical Information: Achieving the Vision, 2002;* Kaiser Permanente
[26] Kaushal, R. et al. Ann Intern Med. 2005; 143:165-173.
[27] Hollmer, M. Healthcare IT spending proves Rx for local firms. Boston Business Journal, October 2004
[28] An info-tech disconnect, Modern Healthcare, February 10, 2003
[29] InformationWeek Research's Evolving IT Priorities 2002 and 2003

medical records in their practices. A similar finding emerges from studies about use of electronic prescriptions. Here the research shows that less than 5 percent of U.S. physicians currently "write" prescriptions electronically.[30]

At the facility level, while 13 to 15 percent of hospitals have implemented some form of CPOE, physicians in the organizations entered less than 25 percent of their orders using the system.[31] Here, however, some progress is being made. According to a recent survey by the American Hospital Association, major health providers are beginning to make significant investments in EHR. AHA's 2004 survey found that in 2004, 64 percent of hospitals had a patient's current medical record (observations, orders, progress notes) - one of the four components of an EHR - compared with 24 percent in 2000.

b. Strategies Underway to Address Barriers to Health Information Technology Adoption

National healthcare leaders in both the public and private sectors are beginning to tackle a number of barriers to HIT adoption. Those barriers include the lack of standards necessary to create interoperable systems; the organizational and clinical process change required in provider institutions and clinician offices; and the lack of financial incentives for HIT.

Standards

Standards play a critical role in achieving interoperability across siloed electronic applications within our healthcare system. Public-private sector collaboratives such as the Markle Foundation's Connecting for Health Initiative and federal Agency-led initiatives such as the Consolidated Health Informatics initiative have made considerable progress in developing consensus and driving the adoption of such standards. To further standards adoption, Health and Human Services (HHS) Secretary Mike Leavitt announced the formation of a national collaboration, the American Health Information Community (AHIC), which will help nationwide transition to electronic health records – including common standards and interoperability. Additionally, some of the nation's larger public and private sector purchasers are beginning to build requirements for standards into their incentive programs and contracts. Also, private sector organizations such as the Certification Commission for Healthcare Information Technology have emerged to begin development of processes for certification of products by such standards.

[30] "A call to Action: Eliminate Handwritten Prescriptions Within 3 Years!" Institute for Safe Medical Practices. http://www.ismp.org/msaarticles/whitepaper.html.
[31] American Society of Health-System Pharmacists Study.

Organizational/Clinical Process Change

A number of initiatives are now underway which are designed to support the level of organizational and clinical process change required to migrate to electronic systems. The draft "Eighth Scope of Work" provides funding to the quality improvement organizations (QIOs) through the Centers for Medicare and Medicaid Services and includes components that require QIOs to provide technical assistance to small physician practices as they begin using electronic health records and other clinical systems. The Agency for Healthcare Research and Quality's National Resource Center for Health Information Technology will play a critical role in not only helping its grantees and contract recipients implement HIT, but serve as a resource to other stakeholders who will be making the migration to electronic healthcare systems over the next several years.

Financing

The issue of financing is probably the largest barrier to HIT adoption in the United States. The current healthcare financing system fails to provide incentives for payers and providers to work together in creating administrative and clinical efficiencies or promoting the quality of care.[32] While providers now bear most of HIT implementation costs, many of the benefits from HIT investment in both quality and efficiency accrue to the payer, not the provider. In fact, one study shows that providers retain only 11 percent of the benefit.

For example, improved disease management that reduces the total cost of care and improves health outcomes actually may represent a loss of revenue to providers, who experience reduced visits or admissions. Thus, there is a misalignment of incentives among those who pay to implement HIT (providers) and those who stand to benefit financially (payers). [33]

In addition to changes in the payment system, there is a need for upfront funding for many institutions and clinicians. Many vital healthcare information technology systems are capital-intensive, but both hospitals and physician groups generally lack substantial capital or sufficient positive cash flow to finance large investments. A number of programs are now underway to clear financial barriers, and are described in further detail in the section "Leadership Within the Private Sector" of (the Arizona Health-e Connection Roadmap briefing paper).

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[32] The Health Technology Center and Manatt, Phelps & Phillips LLP, Spending Our Money Wisely: Improving America's Healthcare System By Investing in Healthcare Information Technology (May 2003).

[33] Markle Foundation Report on "Promoting Electronic Health Records: Incentives and Connectivity" concludes financial incentives will be necessary to accelerate adoption of EHRs in small and medium sized practices. Incentives should total $12,000 to $24,000 per full time physician per year for at least three years (cost per physician over three years estimated at $50,000). Incentives should equate to $3 to $6 a visit of $.50 to $1.00 per member, per month.

2. The Arizona Health-e Connection Roadmap

A. Development

On August 30, 2005, Governor Janet Napolitano issued Executive Order 2005-25 establishing the Arizona Health-e Connection Steering Committee. Their charge was to develop a roadmap for statewide interoperability for electronic health records to reduce costs and enhance the quality of health care. Hundreds of Arizonans representing diverse interests and geographies contributed to the process, serving on the Steering Committee or on one of the various task groups convened to address specific issues.

St. Luke's Health Initiatives and the BHHS Legacy Foundation funded the development of the Roadmap. They contracted with eHealth Initiative, a Washington DC based not-for-profit organization, to mentor Arizona in developing the Roadmap.

The Steering Committee delivered the Roadmap to Governor Napolitano on April 4, 2006. Major components of the Roadmap include:

- Encouraging health information technology adoption among health care providers;
- Identifying key infrastructure components that enable providers to securely exchange health information;
- Implementing both regional and centralized initiatives;
- Developing a not-for-profit, public-private governance organization with representation from all major stakeholders groups to provide leadership implementing the Roadmap; and,
- Creating a funding structure that is value-driven and self-sustaining with many costs borne by those receiving benefit.

B. Transition

Transition to a permanent governance organization will require approximately one year. During this time additional project milestones are to be reached. The first year milestones include:

1. Establish the governance organization;
2. Implement statewide infrastructure projects that support regional HIE efforts;
3. Establish one or two regional health information exchanges; and,
4. Develop a marketing and education plan to encourage stakeholder participation.

II. Award Description

A. Type of Award

The award will be in the form of a grant.

B. Summary of Funding

This program will provide funding to rural health care providers that are implementing health information technology (HIT) in order to improve the quality or efficiency of care, or ultimately lower the cost of health care delivery.

Funding of $1.5 million was appropriated for this purpose for the State fiscal year 2006-07 by the Governor and State Legislature. The number of grants awarded will be determined by the number of applicants, the rank of the applicants after evaluation, and the amount requested by the scored applications. It is anticipated that multiple awards will be made -- the maximum amount allowed for each grant being categorized by the following grant types:

1. Health Information Technology Planning (HITP) Grants; up to $80,000.00
2. Health Information Technology Implementation (HITI) Grants; up to $250,000.00

The State reserves the right to change the maximum amount, dependent upon the number of grants, the amount requested and the ranking.

Funding beyond the first year for the RHITA Grant Program is dependent upon availability of appropriated funds in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the State of Arizona.

Funding will not be provided in advance of work completion, unless agreed to in writing by both the State and a successful applicant. Projects can invoice to the Government Information Technology Agency for work completed at any time, but no more frequently than monthly, unless an exception is agreed to by both parties.

Though the currently appropriated funds do not lapse, and will be available for payment on approved grants after the end of fiscal year 2006-07 (June 30, 2007), no provision current exists to renew this program beyond fiscal year 2006-07.

III. Eligibility Information

A. Eligible / Non-eligible Applicants

1. Eligible applicants are health care providers in one of the following categories:
   a) Non-profit and for-profit health care providers
   b) Health care provider that is part of a tribal government division/agency
   c) Health care provider that is part of a political subdivision (e.g. county, city, or town)
   d) State government department, agency, commission, or budget unit that is categorized as a health care provider (a Project Investment Justification may be required subsequent to an award to a State budget unit).

   Note: Federal agencies are not eligible to be primary applicants, but may participate in a collaboration or partnership benefiting from these grants.

2. Eligible applicants must have a patient base of which 50% or more live in rural Arizona, and must currently deliver health care from a facility owned or operated by the applicant that is located in rural Arizona. Rural Arizona is defined as meeting either of the following criteria:

   a) A county with a population of less than four hundred thousand persons according to the most recent United States decennial census.
   b) A census county division with less than fifty thousand persons in a county with a population of four hundred thousand or more persons according to the most recent United States decennial census

3. Eligible applicants must accept both Medicare and Medicaid.

4. Eligible applicants must comply with all reporting functions required of their organization by the Arizona Department of Health Services, and if not, show how this funding will accomplish such compliance. Compliance with ADHS reporting, however, cannot be the primary outcome of the applicant's grant-related activity.

5. For the purposes of this grant program, for-profit vendors of health information technology products or planning services are not eligible to receive grants directly, nor to be listed as a partner for collaboration purposes. Vendors specified by applicants will be considered "subcontractors."

B. Letter of Intent

A letter of intent is due to the Government Information Technology Agency (GITA) by October 3, 2006. All letters of intent should be mailed, emailed (as an attachment on letterhead) or faxed to:

Brad Tritle
GITA, State of Arizona
100 N 15th Ave, Suite 440
Phoenix, AZ 85007
Fax: (602) 364-4799
Email: btritle@azgita.gov

Please include the email address of the person(s) interested in receiving notices of updated information on the grant RFP.

The letter is an expression of interest, and does not bind the potential applicant to submission of a grant proposal. The letter should list the organization(s) planning to submit the application, the category of grant requested (HIT Planning or HIT Implementation), and the primary activities that are likely to be included in the proposal.

An applicant that does not submit a letter of intent by the due date may still submit a grant proposal, and is encouraged to send a letter of intent at the earliest possible date.

C. Cost Sharing / Matching Funds

Matching funds and cost sharing are not required to apply for a grant through this program, though the presence of matching funds or cost sharing is one criterion included in the evaluation of grant applications.

D. Eligible Costs / Use of Funds

Grant funds may be used for equipment, hardware/software, software development, consulting fees, training fees, or other costs associated with either the planning or implementation of information technology programs by health care providers. Travel costs may comprise no more than 5% of the grant award, with lodging and meals/incidental expenses not to exceed those published for State employees by the State of Arizona Department of Administration General Accounting Office (see: http://www.gao.state.az.us/docs/manuals/accounting/sect2/textiid1.pdf)

Non-eligible costs include all non-direct costs and pro-rated overhead, including but not limited to the following:

• Acquisition, construction, improvement, lease, survey, maintenance, or management of facility, plant, real property, or related and incidental expenses;
• Purchase, lease, or repair of vehicles, furnishings, (routine) supplies, or consumables;
• Acquisition, renovation, or replacement of facility plumbing, water sprinkler system, air cooling/heating units, fire alarm/security system, or costs associated with facility certification, compliance or safety requirements;
• Consulting or professional fees for the preparation, review, or submission of the grant application

III. Grantee Duties for Successful Projects

Grant recipients will be required to conduct a rigorous and continuous evaluation of their projects. The Government Information Technology Agency (GITA) will perform continuous oversight for all grant recipients, and continuation of funding for any successful grant applicant during the term of the grant will be subject to the approval of the director of GITA.

Applicants awarded a grant will be expected to:

1. Submit a final workplan and budget that will become a part of the grant contract;
2. Enter into a contract with the Government Information Technology Agency (GITA) to perform the work per the budget described in the application, with any modifications requested by GITA and agreed to by the grantee.
3. Submit a final abstract of 300 words or less describing the project – to be used for providing the general public with an official summary of the project.
4. If data exchange (e.g. HIE) is involved, complete an assessment of privacy and security issues related to your project, and how you plan to address them;
5. Participate in at least two site visits or conference calls to report on progress, barriers, plans, and lessons learned;
6. Submit a midpoint and final written narrative report on progress and accomplishments during the grant period. The final report must be submitted within 30 days of the grant contract expiring.; and
7. Submit expenditure reports with the two narrative reports described above, detailing expenditures to date based on the original budget.

A final 10% of the total grant award may be withheld until duties number 5 and 6 are completed.

IV. Application and Submission Information

A. Contact Information

Additional RHITA Grant Program guidance and application packages, and program information is available from the following point of contact:

Brad Tritle
Strategic Initiatives Manager
Government Information Technology Agency
State of Arizona
100 N 15th Avenue, Suite 440
Phoenix, Arizona 85007
Tel: 602 364 4775 or 602 364 4482
Email: btritle@azgita.gov

B. Content and Form of Application and Contract

A complete and acceptable application, with attachments, and this program guidance document will comprise the required elements for the grant award contract. For applications to be considered complete and acceptable for submission, they must include the following:

1. Completed application documents, including the following documents (and any further supplementation with spreadsheets provided by the applicant), which are embedded in the application:
    a. Applicant Information Document
    b. Element One Document
    c. Element Two Document
    d. Element Three Document
    e. Element Four Document
    f. Element Five Document
    g. Element Six Document
    h. Element Seven Document
    i. Element Eight Document
    j. A signed Terms, Conditions and Offer document
2. Copy of CMS letter showing Medicare/Medicaid provider number
3. Copy of letter from IRS showing non-profit status, or an official letter indicating status as a tribal government, government agency or political subdivision of the State (e.g., county, city, or town). If a for-profit corporation, a letter from an officer or principal of the organization indicating the type of corporation and in which state it is incorporated.
4. Letters from partners, if any, stating their intent to collaborate on, or provide support for, the project – signed by an appropriate officer or executive from each partner.

Additional documents, such as those providing proof of sufficient insurance, may be required to be submitted subsequent to an award.

C. Submission Date, Time, Confidentiality, and Public Record

1. All applications must be submitted to the Government Information Technology Agency at 100 N. 15th Avenue, Suite 440, Phoenix, Arizona no later than 3:00 p.m. MST, on October 20, 2006, at which time, the name of each applicant will be publicly read and recorded. All other information regarding the application will be kept confidential during the evaluation process. All applications are open for public inspection after the grants are awarded. Facsimiles (faxes) are not acceptable for submission.

D. Number / Type of Copies

Both of the following items are required:

1. One original and five bound hard copies
2. One electronic copy on CD-ROM (including scanned or electronic versions of required attachments) or by email (if 10 Megabytes or less) as a single pdf document to btritle@azgita.gov (email does not negate the need for hard copies by deadline; we must have both hard copies and electronic copy).

V. Application Review Information

A. Categories

Procedures for assessing the technical merit of grant applications have been instituted, to both provide for an objective review of applications, and to assist the applicants in understand the standards against which their applications will be evaluated.

Review criteria are outlined below with specific detail and associated scoring points.

Criterion 1: Need (20 points)

Applicant must state how the project will improve the quality and/or efficiency of health care delivery. Applicant must outline the needs of the community/communities and/or the health care provider(s) as they relate to quality and efficiency improvement, and specifically identifies the problem or problems the grant funds will be used to address. The applicant must assess the likelihood of the project occurring absent grant funding.

Criterion 2: Collaboration (10 points)

Application will be scored according to how well it represents a partnership of stakeholders that will be participating together in the designated health information technology adoption program.

Criterion 3: Industry Standard Technology (10 points)

Applicant must state how it intends to implement health information technology which adheres to industry standards, including any appropriate standards issues by the Certification Commission for Healthcare Information Technology (CCHIT), ANSI, and the State of Arizona Government Information Technology Agency.

Criterion 4: Plan for the future exchange of information (10 points)

Applicant will be scored as to how it intends to participate in efforts to establish an exchange of health information locally, regionally, statewide, or nationwide, and this project will aid in achieving such exchange.

Criterion 5: Medically underserved area (10 points)

Applicant will be scored regarding its presence of facilities in a primary care area designated as medically underserved.

Scoring for this criterion will be based on the Primary Care Score most recently calculated by the Arizona Department of Health Services (ADHS) and available on the ADHS website as of September 1, 2006. Applicant can identify their primary care area and associated score (available in Statistical Profile) using following link: http://azdhs.gov/hsd/profiles/profiles1.htm

In the event that the applicant has facilities in multiple primary care areas, the applicant will be asked to provide the locations, their associated scores, and calculate an average of the location's scores.

Primary Care Area (PCA) Scores will be evaluated and scored as follows:

60 to 99:	10 points
44 to 59:	7 points
32 to 44:	4 points
8 to 32:	1 point

Criterion 6: Matching Funds or Cost-Sharing (10 points)

Matching funds and cost sharing are not required to apply for a grant through this program, though the presence of matching funds or cost sharing is one criterion included in the evaluation of grant applications.

Matching funds for this program, if used in the application, must be in addition to and therefore supplement funds that would otherwise be made available for the stated program purpose. Match is restricted to the same use of funds as allowed for the State funds.

Matching funds will be evaluated and scored as follows:

90 to 100% match:	10 points
80 to 89% match:	9 points
70 to 79% match:	8 points
60 to 69% match:	7 points
50 to 59% match:	6 points
40 to 49% match:	5 points
30 to 39% match:	4 points
20 to 29% match:	3 points
10 to 19% match:	2 points
1 to 9% match:	1 point

In programs where a cash or in-kind match is utilized, the grantee must provide sufficient documentation to demonstrate that the match is indeed being provided to supplement the program for which the funds are being provided. All contributions, including cash and third party in-kind, shall be accepted as part of

the recipient's cost sharing or matching when such contributions meet all of the following criteria

1 Are verifiable from the recipient's records
2 Are not included as contributions for any other federally or State-assisted project or program.
3 Are necessary and reasonable for proper and efficient accomplishment of project or program objectives.
4 Are allowable under the applicable cost principles.
5 Are not paid by the State government under another award

Matching funds must follow the basic guidelines of factors affecting allowed costs. Matching funds cannot be other State funds (supplanting) and cannot be charged to more than one State program.

Recipients must maintain records that clearly show the source, the amount, and the timing of all matching contributions. In addition, if a program or project has included within its approved budget contributions which exceed the required matching portion, the recipient must maintain records and document them in the same manner as it does the awarding agency funds and required matching shares.

Matching contributions need not be applied at the exact time or in proportion of the obligation of the State funds.

Criterion 7: Support Requested (10 points)

Evaluators will assess the reasonableness of the proposed budget in relation to the objectives, the complexity of the activities, and the anticipated results. A budget narrative as well as a line item budget will be required.

Criterion 8: Work Plan (20 points)

The application will be scored as to how well it describes, in a work plan, the quality and/or efficiency improvement activities to be planned or implemented through information technology under this program. The number of patients and doctors positively impacted by the proposed plan will also be considered in the scoring.

The work plan should include:

1. Identification and description of objectives to be achieved by the grant funds.

2. A clear description indicating how the objectives are to be achieved, and how success will be measured.

3. A detailed time line that includes each planning or implementation activity and identifies responsible staff and/or contractors.

4. Challenges that are likely to be encountered in the planning or implementation activities described in the work plan, and approaches that will be used to resolve such challenges.

5. A sustainability plan and proposed funding mechanism, to either:
   1) Implement the plan, if it is a Health Information Technology Planning (HITP) Grant
   2) Continue the necessary maintenance, support, and other applicable activities, if it is a Health Information Technology Implementation (HITI) Grant.

B. Legislative Requirements

This grant program in its entirety is designed to comply with all requirements within the Arizona Revised Statutes, including ARS 41-2702 for "Solicitation and Award of Grant Applications."

C. Pre-application Conference

A pre-application conference will be held on Friday, September 15, at 1:00 p.m. at 100 N 15th Avenue, Conference Room 300 (a, b, c), Phoenix, Arizona 85007. Statements made at the pre-application conference are not amendments to the request for grant applications, unless a written amendment is issued. A teleconference bridge will also be available by calling 1-800-504-8071, and entering conference code 364 4793.

D. Award and Project Start Dates

Evaluation of the grants will begin upon receipt, and it is anticipated that awards will be made within 30 days. We estimate the project start date to be December 1, 2006.

VI. Award Administration Information

A. Award Notice

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the evaluation committee's assessment of the application's merits and weaknesses, and whether the application was selected for funding. Applicants who are selected for funding may be required to respond in a satisfactory manner to conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

B. Reporting

GITA requires that successful applicants:

1. Report on technical and financial progress monthly, using format established by GITA. These reports will be due on the first of the fifteenth of the month, starting the second month of award;
2. If data exchange (e.g. HIE) is involved, complete an assessment of privacy and security issues related to your project, and how you plan to address them;
3. Participate in at least two site visits or conference calls by GITA personnel to report on progress, barriers, plans, and lessons learned (GITA personnel may have contact more often to assess status of project, as deemed appropriate by GITA);
4. Respond in writing within 5 business days to any concerns or questions GITA personnel have expressed in writing during the term of the grant contract;
5. Submit a midpoint and final written narrative report on progress and accomplishments during the grant period. The final report must be submitted within 30 days of the grant contract expiring; and
6. Submit expenditure reports with the two narrative reports described above, detailing expenditures to date, and mapped to the original budget.

Failure to comply with any of the above reporting requirements will leave the grant award and contract subject to termination at the discretion of the GITA director.

C. Grantee Conference

Successful applicants will be required to submit a presentation and participate in a half-day "grantee conference" to be held in the Greater Phoenix area. It is estimated that this conference will be held sometime in May or June of 2006. The purpose of this conference is to provide peer exchange, and communication to the executive and legislative branches regarding the status of the grant program and awarded projects. Proposed attendees will be determined by GITA, in consultation with the successful applicants. Expenses for two representatives from each successful applicant to attend this conference may be included in the grant application budget.